CHAPTER VII.

INFLAMMATION OF COWPER'S GLANDS.

This is a rare complication of urethral gonorrhœa in the male, but sometimes occurs at about the same period as epididymitis, viz., during the third or fourth week, or later, after the appearance of the discharge.

The patient experiences a feeling of tension and pain in the perinæum near the bulb of the urethra, which is aggravated in the sitting posture, by walking, and by friction of the clothes. Upon palpation a small tumor of the size of a bean is felt upon either side of the median line; its form ovoid or pyriform, with its base directed towards the anus and its apex connected with the bulb. This tumor may encroach upon the urethra and cause dysuria, and, on introducing a catheter, an obstruction may be met with near the bulb. Defecation is also painful.

Resolution is possible, but in most cases suppuration takes place, sometimes in the gland itself, but more frequently in the surrounding cellular tissue, and the abscess extends to the base of the scrotum, often crosses the raphé to the opposite side, and, in rare instances, involves the whole of the perinæum. The matter usually finds exit in the perinæum, and an opening may also form in the urethra, giving rise to a urinary fistula; sinuses may also be formed in various directions.

In a patient who died of some intercurrent disease, Littré found "the body of the gland extremely hard, red, and tumefied, and a greenish-yellow fluid could be pressed out of it. The duct of the left gland was distended with a similar fluid, and its tunics were of a reddish color, and harder and thicker than normal. The urethra, in front of the openings of the glandular ducts, was reddened over a space of about four lines in width, and in the middle of this space there was a rounded ulcer half a line in diameter which had eaten away a large portion of the opening of the left duct and a small portion of the canal in the neighborhood."[1]

The gland to the left of the raphé is said to be most frequently attacked. Sometimes both glands are involved. The formation of matter is often accompanied by general febrile disturbance. Since these glands are not surrounded by a fibrous capsule like the prostate, urinary infiltration is likely to occur when the abscess breaks into the urethra, and we may have diffuse suppuration of the cellular tissue. Tarnowski speaks of atresia of the urethral openings of the

[1] Littré, as quoted by Fournier.

ducts as one of the results of this affection; the remainder of the duct becomes dilated, cyst-like, and may interfere with the passage of urine by its pressure on the urethra.

The treatment of this affection consists in the early application of leeches, hot baths, poultices, and rest, and incision of the tumor so soon as it is evident that resolution is impossible, even if fluctuation be not clearly detected.

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CHAPTER VIII.

AFFECTIONS OF THE CORPORA CAVERNOSA.

In the course of an attack of gonorrhœa, the inflammation may extend to the corpora cavernosa and produce an effusion of plastic lymph, which will obliterate the cavities of these bodies and interfere with complete distention in the state of erection of the penis. "The same effect may be produced by small apoplectic deposits in the substance of the corpora cavernosa, the cicatrization of which always entails a deposit of a certain quantity of plastic tissue" (Robert).

In consequence of such deposits the penis may be bent in such a manner as seriously to interfere with coitus; the concavity of the bend looking upwards, downwards or laterally, according as the deposit is situated in either of these directions. If both bodies be invaded at any one point, the portion of the penis behind, *i. e.*, towards the pubes, may alone be distended, while the anterior portion remains flaccid. The occurrence of these deposits is attended at the outset by a fusiform swelling of the penis and pain on deep pressure. They usually continue in an indolent condition, are but little amenable to treatment, and may be a source of great annoyance and mental despondency.

The same condition as that now described may be the result of mechanical injuries to the penis when erected, or of gummy deposits occurring in syphilis.

As to treatment, the attempt may be made to induce absorption by local frictions with an ointment containing mercury or the iodide of lead, and by the internal use of the iodide of potassium.

Chronic circumscribed Inflammation of the Corpora Cavernosa.—Under this title Van Buren and Keyes[1] first clearly described an affection which was little known and barely referred to in works on Surgery and Venereal Diseases, although mentioned by H. J. Johnson[2] in 1851. The affection is free from pain and progresses slowly, until the patient notices a small lump, which is painful on erection of the penis. Upon examination we find a hard, firm plate of tissue, a line or two in thickness, situated in the superficial portion of the corpus cavernosum. Its margins are sharply defined and regular, or they may be uneven, slightly nodulated and perhaps thickened. The deeper parts seem to be free from disease. The induration of the plate is variable, in some cases being cartila-

[1] A Practical Treatise on Diseases of the Genito-Urinary Organs, New York, 1874.
[2] Lancet, Lond., 1851.

ginous, but it always has a kind of elasticity, which gives to the finger a sensation quite different from that offered by the bony and calcareous plates sometimes found here. The lesion may occupy one corpus cavernosum or both, and always seems to spring from the median line on the dorsum of the penis. The plate generally has an ovoid shape, but in two instances, in which the disease was seated about an inch behind the corona glandis, I found on either side a horn-like process or offshoot extending around to the frænum along the course of the lymphatics. The lesion is always circumscribed and seldom exceeds half an inch in diameter; I have never seen a plate more than two inches in diameter. When each corpus cavernosum is invaded the plates may be firmly united on the dorsum of the penis, or they may be separate. There is no increase of heat in the affected parts, nor is the skin above the tumor at all abnormal. The affection is extremely chronic and sometimes intermittent. The plates may grow antero-posteriorly, or they may remain stationary, or they may extend in one direction as they disappear at the opposite end, thus travelling over nearly the whole length of the corpus cavernosum. Spontaneous pain is rare, but the parts are always sensitive to pressure, and there may be a dull aching sensation along the border of the patch. The lesion interferes with erection, the penis being drawn towards the affected side; when it involves both sides of the penis the organ may be bent upwards to such a degree as to prevent coitus.

The affection has been met with only in those of middle or advanced age. Its *etiology* is very obscure. In some cases it seems to have resulted from injury. Although occurring in those who have had syphilis, gonorrhœa, or stricture, there seems to be no relation between the diseases.

We know nothing positive of the *pathology* of the affection, but it is probably, as suggested by Keyes, "in its essence a chronic inflammation of a peculiar kind affecting the erectile tissue at a certain point, and so thickening and stiffening the naturally thin walls of the areolæ (probably filling up the interstices with fibrinous exudation), that they cannot be distended with blood during erection of the rest of the organ."

The *prognosis* of the disease is uncertain. There is no case on record in which it disappeared altogether. In most cases the plates persist for many years; sometimes they diminish very markedly in size, but they never become excessively large nor undergo degeneration.

Treatment of various kinds has been tried with little if any benefit. I fully agree with Van Buren and Keyes in deprecating the use of blisters and counter-irritants, since they are painful and inefficacious. Friction with dilute mercurial ointment and the occasional use of the constant current, with iodine internally, may promote absorption of the deposit.

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CHAPTER IX.

LYMPHANGITIS AND ADENITIS.

GONORRHŒAL lymphangitis may either be seated in the principal trunks or in the reticular network of these vessels.

I. In the former, the course of the inflamed lymphatics can be traced as reddish lines, running, as is usually the case, along the dorsum of the penis from the prepuce towards the pubes. There may be one or several. In the latter case, they may be united by transverse bands of erythema, corresponding to the anastomoses of the vessels. To the touch they resemble hard or knotted cords, which can be separated by the fingers from the adjacent tissues. Their sensitiveness varies with the amount of inflammation. There is often some œdema of the prepuce or of the penis, and tenderness of the inguinal ganglia. This state of things almost invariably terminates in resolution. Suppuration is reported to occur in rare instances in the form of several small circumscribed abscesses, which are usually of little moment, but which may undermine the skin to some extent and demand surgical interference (Hardy). Zeissl says he knows men who have lymphangitis every time they have the clap.

Fournier speaks of another form of this affection taking place (*à froid*), without any signs of acute inflammation, and recognizable only by the hard and indolent cord or cords, perceptible to the touch along the dorsum of the penis, and readily mistaken for the indurated lymphangitis attendant upon the initial lesion of syphilis.

Inflammation of the lymphatic trunks along the dorsum of the penis has been mistaken for dorsal phlebitis. According to Fournier, the latter is an exceedingly rare affection, a few cases having been seen by Ricord. It is distinguishable from the former by the greater amount of œdema, by the impossibility of grasping and isolating the vessel between the fingers, and by the inguinal ganglia remaining unaffected.

II. The second form of lymphangitis, the one in which the general reticular network of the lymphatic vessels is involved, is usually confined to the prepuce, and is responsible for many of the cases of phimosis and paraphimosis and their sequelæ (abscesses, perforation of the prepuce, etc.) which have been described in another chapter. The part affected is of a uniform rose or red color, more or less tumefied and exceedingly sensitive. The trunks of the vessels along the dorsum and the glands in the groin usually show signs of participation.

In very rare cases the whole penis is involved, attains an enormous size, is twisted upon itself at its extremity, and is the seat of the most violent pain. Micturition is difficult and painful, erections excruci-

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ating. General febrile reaction, chills, fever, loss of appetite and even delirium (it is said) may occur.

In most cases, even these severe symptoms terminate without any untoward result. Suppuration, however, is a consequence to be feared. "When this takes place it is almost always seated in the prepuce. Very rarely it involves the cellular tissue lining the sheath of the penis. The abscess shows great tendency to destroy the mucous membrane of the prepuce, and to empty itself towards the glans. When finally emptied, the swelling of the prepuce subsides, the tension disappears, the pains cease, and the skin can be felt to be thinned at the point affected. In some cases this thinning of the skin is so great that the membrane loses its vitality, and is affected with gangrene. A perforation results, through which the glans may be seen. This accident is not the only one to which the patient is exposed. One of the most common, and at the same time least serious, consists in a hard œdema limited to that portion of the prepuce corresponding to the frænum, and which may be very persistent. In other patients, the edges of the opening of the abscess become indurated, and it becomes difficult to uncover the glans. Finally, in persons predisposed to phimosis, there remains a narrowness of the preputial orifice or an induration of the whole membrane" (Hardy).

Treatment.—The treatment of gonorrhœal lymphangitis consists in rest in the horizontal posture, elevation of the genitals, full baths, local bathing with hot water, and incision of any abscess as soon as formed. Rules for treatment in cases of phimosis have already been given.

ADENITIS.—It is rare to observe anything more serious in the inguinal ganglia in cases of gonorrhœa than slight enlargement and tenderness, which disappear in a few days. According to the statistics of the Antiquaille Hospital at Lyons, an attendant bubo is met with in only one out of every fourteen cases of gonorrhœa.[1] It is at once recognized by the physician and patient by the enlargement and tenderness of one or more glands in the groin, and it may occasion considerable pain and uneasiness in walking and standing. Buboes attendant upon gonorrhœa, uncomplicated with chancroid, are "simple" buboes; of which a fuller description will be given hereafter, when speaking of buboes in general. They may generally be made to disappear in a few days by keeping the patient quiet, and producing a little counter-irritation by painting the skin over them daily with tincture of iodine. It is only in scrofulous subjects, or in consequence of violence, excessive fatigue, or general depressing influences, that they ever exhibit a tendency to suppurate. I have known of one instance of a man suffering from gonorrhœa, without the slightest trace of venereal ulceration, who after exposure to great hardship upon a wreck, had a suppurating bubo that confined him to his bed for six months.

[1] Gaz. d. hôp., Paris, No. 141, 1861.

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